STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

P.O. Box 45010, Olympia, Washington 98504-5010

March 26, 2004

Mr. Dennis G. Smith, Director
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
Mail Stop C5-21-17
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Smith:

Based on our recent negotiations with Centers for Medicare and Medicaid Services (CMS) Center for Medicaid and State Options (CMSO) staff, we are requesting an expedited amendment to our recently approved Medicaid demonstration application (Project No. 1 l-W-00180/0). This amendment is requested because our state legislature enacted a lower premium design for Medicaid Categorically Needy (CN) Optional children than had been approved by the Department of Health and Human Services (HHS).

Our HHS approved waiver allows a two-tier premium design for CN Optional children. Families with incomes between 100% and 150% of the federal poverty guideline (FPG) would pay a $15 per month premium. Families with incomes between 151 % and 200% of FPG would pay $20 per month. Families would be subject to a three premium maximum so that costs would be less than 3.0% of gross income for any family.

As outlined in my March 15, 2004, acceptance letter, our State Legislature enacted a 2004 Supplemental Budget (SHB 2459), which now directs the Department of Social and Health Services (DSHS) to implement premiums, effective July 1,2004. CN Optional children in households above 150% of FPG will pay $10 per month per child, limited to three-children per household. This three-person maximum would limit families cost to no more 1,1% of gross household income.

CN Optional children in households between 100% and 150% of FPG would not be charged premiums at this time.

As a condition for proceeding with the demonstration, we want to retain the ability to increase premiums up to the amounts approved under the waiver. We want to retain flexibility for the Governor and State Legislature to adjust premium requirements and amounts as needed over the five-year demonstration period. We agree that any change in eligibility groups or premium amounts not approved in the waiver would require Washington to amend our demonstration application.

In my March 15th acceptance letter, we proposed to treat a change within the approved demonstration parameters as a "technical change in policy and procedures" as described in the Special Terms and Conditions (STC) Section IV.3 (Amending the Demonstration). As set forth in STC Section VII. 1 (Operational Protocol Timelines and Requirements), our agency would submit a technical change request at least 90-days prior to the proposed change.

We have been advised that CMSO will not approve these conditions. According to staff, any changes in coverage groups or amounts that are within the parameters approved for Project No. 1 l-W-00180/0 must be treated as an "expedited amendment" to our waiver and not a change to policies and procedures.

However, we also have been told the CMSO would allow the "demonstration eligibles" used for tracking and budget neutrality purposes could continue to be those approved in STC Attachment A.3.C. The "demonstration eligibles" population would be the entire CN Optional children population: (a) under age 1 whose family income exceeds 185 percent FPG; (b) age 1 through 5 whose family income exceeds 133 percent FPG; and, (c) age 6 through 18 whose family income exceeds 100 percent FPG.

We believe there are mutual benefits to our respective agencies in continuing to use this broader definition. This group represents an already defined eligibility group that both CMS and DSHS can track and report on. Secondly, we anticipate that our State Legislature will be considering increases to premiums in the forthcoming 2005-07 biennium (July 1,2005 through June 30,2007). The ability to have a set demonstration population that does not change from year to year would reduce budget neutrality complexity and waiver administration for both our agencies. Finally, subject to conditions outlined below, it provides the Governor and State Legislature with more flexibility to administer its Medicaid program while assuring the necessary CMS oversight of the demonstration.

As a condition for adopting the Project No. 11-W-OO180/0 definition of "demonstration eligibles", CMS will agree to an "expedited amendment change" process. Under revised STC, Washington State would agree to submit any proposed amendment that is within the parameters approved in our July 15,2003 application and the approved demonstration, including eligibility groups and maximum premium amounts, no later than 90 days prior to the date of implementation of the change(s). CMS will respond within 30 days of receipt of the amendment regarding any issues or areas for which clarification is needed in order to fulfill the STC. CMS will make a final decision and submit a written response to the State no later than 30 days prior to the date of the implementation of the change(s).

Finally, we want to request that the effective date for the demonstration be changed from February 1, 2004 to July 1, 2004. The February date had been selected to coincide with our application request to start premiums on February 1st. However, our State Legislature moved the premium start date to July 1st to give us time to complete our negotiations with CMS. Adopting a July 1st effective date will make reporting and tracking more relevant and will tie to the actual demonstration implementation.

Enclosed is a copy of the amended STC that incorporates the expedited amendment change (see new STC Section VII.2). Also per CMSO staffs request, enclosed are revised budget neutrality projections that incorporate the changes in children subject to premiums and the premium amounts.

As set forth in your February 13, 2003, STC Section VII. 1, we will submit an Operational Protocol document at least 60 days prior to program implementation. The document will address the requirements outlined in Section VII.2. We also will submit an evaluation design as described in STC Section 11.2 within 90 days of our award date of February 1, 2004.

After over two-and-one-half years of negotiation with CMS on our Medicaid reform waiver and with significant reductions in the scope of our demonstration request, we believe that CMS should agree to our proposed expedited amendment process request. It is well within the reasonable scope of an 1115 demonstration project.

With the changes described above, and acknowledgement that we are continuing to negotiate on the AI/AN exemption, we will accept the amended STCs enclosed in this letter. Doug Porter and his staff will coordinate the submittals and other necessary information with our Title XIX Demonstration Project Officer, Julie Harkins.

Sincerely,

DENNIS BRADDOCK
Secretary

Enclosure

cc: Governor Locke
Douglas Porter
Liz Dunbar
Stan Marshbum
Marty Brown
Wolfgang Optiz
Ree Sailors
Jean Shell
Richard Fenton
Mike Fiore
Julie Harkins
Karen 0'Connor
Carol Crimi

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: 11-W-00180/0 (Title XIX Medicaid funding)

TITLE: Washington Medicaid Reform Waiver

AWARDEE: State of Washington Department of Social and Healtl

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I. PREFACE

The following are Special Terms and Conditions (Special Terms and Conditions) for the Washington State's section 1115 demonstration program, entitled Washington Medicaid Reform Waiver, Project No. 1 l-W-00180/0. The Special Terms and Conditions have been arranged into the following subject areas: General Requirements and Agreements, General Reporting Requirements, Legislation, Assurances, and Operational Protocol.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter.

The state agrees that it will comply with all applicable Federal statutes relating to nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

II. GENERAL PROGRAM REQUIREMENTS AND AGREEMENTS

1. **Extension or Phase-out Plan.** No later than 18 months prior to the expiration of the demonstration, the State must notify CMS whether it plans to request an extension of the demonstration. Requests for extensions will be due no later than 1 year prior to the expiration of the demonstration. If the State does not intend to request an extension, it must submit to CMS a phase-out plan no later than 1 year prior to the expiration of the demonstration. The phase-out plan is subject to CMS review and approval.

2. **Evaluation.** The State shall submit to CMS for approval within 90 days from the award of the demonstration a draft design of an evaluation design. At a minimum, the report shall include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will discuss the outcome measures that will be used in evaluating the impact of the demonstration during this extension period, particularly among the target population. It will discuss the data sources and sampling methodology for assessing these outcomes. The evaluation design must include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those other initiatives occurring in the State. The report will identify whether the State will implement the evaluation, or select an outside contractor for the evaluation. CMS will provide comments on the report within 30 days of receipt, and the State will submit a final report within 30 days of receipt of CMS comments.

   The State will implement the evaluation design, and submit to CMS a draft evaluation report 120 days prior to the expiration of this demonstration. CMS will provide comments within 60 days of receipt of the report. The State shall submit the final report prior to the expiration date of this demonstration.

3. **CMS Right to Suspend or Preclude Demonstration Implementation. The CMS may** suspend or preclude Federal Financial Participation (FFP) for State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.

4. **State Right to Terminate or Suspend Demonstration.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. If the State chooses to terminate this demonstration before the expiration date, it will notify CMS in writing at least 30 days prior to terminating services to participants. If CMS or the State terminates the demonstration, the State will, at least 30 days prior to terminating services, notify the participants of the services of the action it intends to take, notify them of the effective date of the action, and how the action will affect the participants.

5. **CMS Right to Terminate or Suspend Demonstration Operation.** During demonstration operation, CMS may suspend or terminate FFP for this project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination. The effective date of such action shall not be fewer than 45 days from the date of notice. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the State materially failed to comply. The CMS reserves the right to withhold waivers and authority for pending FFP for costs not otherwise matchable or to withdraw waivers or authority for costs not otherwise matchable at any time, if it determines, after good faith consultation with the State, that granting or continuing the waivers or authority for costs not otherwise matchable would no longer be in the public interest. If the waiver or authority for costs not otherwise matchable is withdrawn, CMS will be liable only for normal closeout costs.

III. GENERAL REPORTING REQUIREMENTS

1. **Monthly Progress Calls.** Before and for 6 months after implementation, CMS and the State will hold monthly calls to discuss demonstration progress. After 6 months of operation, CMS and the State will determine the appropriate frequency of progress calls.

2. **Quarterly and Annual Progress Reports.** The State will submit quarterly progress reports that are due no later than 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include and overview of the past year as well as the last quarter, and will serve as the annual progress report. These reports must include information on operational and policy issues appropriate to the State's program design and provide progress on the evaluation. The report must also include information on any issues that arise in conjunction with the demonstration.

3. **Final Report.** At the end of the demonstration, a draft final report must be submitted to CMS for comments. The CMS' comments shall be taken into consideration by the State for

incorporation into the final report. The CMS's document *Author's Guidelines: Grants and Contracts Final Reports* is available to the State upon request. The final report is due no later than 180 days after the termination of the project. The final report will incorporate the final evaluation report, or it will be provided at the same time as a stand-alone document.

IV. LEGISLATION

1. **Changes in the Enforcement of Laws, Regulations, and Policy Statements. All** requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. If the law, regulation, or policy statement cannot be linked specifically with program elements of the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

2. **Changes in Federal Law Affecting Medicaid.** The State will, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt state section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

   If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology to CMS for complying with the change in law. If the methodology were consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

3. **Amending the Demonstration.** Washington will request modifications to the demonstration by submitting revisions to the protocol for CMS approval. These modifications will include technical changes in policy and procedures. Substantive changes to the demonstration design (i.e., family planning expansion, and the inclusion of institutionalized individuals within the waiver population) will require submission of a formal amendment to the proposal and advance CMS approval. The State will work with CMS in amending the waiver application in the later stages of the demonstration program.

V. COST SHARING

1. Demonstration Population. Premium amounts for demonstration population eligibles (Categorically Needy optional Children) are set forth in the State's July 18, 2003 proposal, but may be changed by the State, with CMS prior approval, through an amendment to the State's Operational Protocol (as described in section VII of these Special Terms and Conditions). Prior to implementing any exemption for American Indian and Alaska Native children from premiums, as requested in the demonstration application, the following steps must be completed. Washington must submit to CMS an explanation of how such an exemption is consistent with the strict scrutiny test applicable for race, color or national origin classifications under title VI of the Civil Rights Act of 1964. Washington's explanation will be subject to review and approval by the appropriate components of the Department of Health and Human Services.' Such an exemption maybe implemented only if the explanation is accepted by the Department.

VI. ASSURANCES

Acceptance of the Special Terms and Conditions of Approval constitutes the State's assurance of the following:

1. **Preparation and Approval of the Operational Protocol.** Prior to service delivery under the demonstration, an Operational Protocol document, which represents all policies and operating procedures applicable to the demonstration, will be prepared by the State and approved by CMS. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the Special Terms and Conditions of Approval, and that approval of changes in premium levels is discretionary with CMS. *Requirements and required contents of the Operational Protocol are outlined in Section VII of these Special Terms and Conditions.*

2. **Adequacy of Infrastructure.** Adequate resources for implementation, monitoring activities, and compliance with the Special Terms and Conditions of the demonstration will be provided by the State.

3. Evaluation and Monitoring Design. The State will conduct formative and possible outcome evaluations of the impact of the demonstration on participants and eligibles. The State acknowledges the importance to CMS of formative evaluation to the operation, quality improvement and possible modification to innovative demonstration initiatives.

4. Budget Neutrality. The cost of services provided during the demonstration will be no more than 100 percent of the cost to provide Medicaid services without the demonstration.

5. Public Notice and Consultation. The State will comply with the public notice requirements issued via September 27, 1994 edition of the *Federal Register*, Vol. 59, No. 186 dated September 29, 1994, and Centers for Medicare & Medicaid Services (CMS) requirements regarding Native American tribal consultation.

VII. OPERATIONAL PROTOCOL

1. **Operational Protocol Timelines and Requirements.** The Operational Protocol will be submitted to CMS no later than 60 days prior to program implementation. The CMS will respond within 30 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the Special Terms and Conditions, those issue being necessary to approve the Operational Protocol. FFP is not available for Medicaid Assistance Payments prior to CMS approval of the Operational Protocol. The FFP is available for post-approval project development and implementation, and compliance with Special Terms and Conditions. Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures will be submitted for review by CMS. The State will submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

2. **Expedited Amendment Changes.** If the State wants to change which eligibles within the "demonstration eligibles" as defined in Attachment A.3.c are subject to premiums, or change the amount of the premiums no greater than the amounts submitted in the State's July 18, 2003. waiver application and approved by CMS on February 13. 2004 as Project No. 11-W-00180/0, the State will submit an amendment request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s). The CMS will respond within 30 days of receipt of the amendment regarding any issues or areas for which clarification is needed. The CMS will make a final decision and submit a written response to the State no later than 30 days prior to the date of the implementation of the change(s). Substantive changes beyond those described above will require submission of a formal amendment to the proposal and advance CMS approval.

3. **Required Contents of Operational Protocol:**

   a) **Organization and Structural Administration.** A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. Include details such as a timeline of demonstration implementation tasks prior to and post implementation, including steps, estimated time of completion, and who will be responsible for items.

   b) **Reporting Items.** A description of the content and frequency of each of reporting items as listed in Attachment A of this document.

   c) **Premiums.** A description of the calculation and collection of applicable premiums. Include the following:

      - Premium amounts,
      - How they were calculated;

- How they will be reported to CMS (refer to items 2.d. and 6. of Attachment A of this document); and,
- The process through which enrollees and providers will be informed of enrollee financial obligations.

d) **Premium Protections.** A description of the enrollee protections in place regarding State disenrollment of enrollees due to non-compliance with premium requirements for demonstration participation, and how enrollees will be informed. For example:

- The grace period during which enrollees may make applicable premium payments without termination from the program;
- How the State will notify the enrollee that he or she has failed to make the required payment and may face termination from the program if the payment is not made;
- How the individual will be assured the right to appeal any adverse actions for failure to pay premiums; and,
- The process in place to re-enroll the individual in the demonstration if payment of the required premium is paid.

e) **Outreach/Marketing/Education.** A description of the State's outreach, marketing, education, staff training strategy/schedule. Include in the description:
- Information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers, or contracted parties);
- Types of media to be used;
- Specific geographical areas to be targeted;
- Locations where such information will be disseminated;
- Staff training scheduled, schedules for State forums or seminars to educate the public; and,
- The availability of bilingual materials/interpretation services and services for individuals with special needs. Include a description of how eligibles will be informed of cost sharing responsibilities and the training provided to State staff regarding educating beneficiaries on the universe of XIX program options available to them.

f) **Eligibility/Enrollment.** A detailed description of the population of individuals eligible for the demonstration (and eligibility exclusions). Describe the processes for the following, and include the State agency responsible for each of the processes:
- Eligibility determination;
- Annual redetermination;
- Intake, enrollment, and disenrollment; and,

g) **Quality.** Describe the State's overall quality assurance monitoring plan. The plan should include, at a minimum, the following:

- A discussion of how the State will monitor operations of the program (personnel and systems);
- The system in place to trigger and alert State staff to issues that need attention;
- All quality indicators to be employed to monitor service delivery under the demonstration and the methodology for measuring such indicators;
- The system to be put in place so that feedback from quality monitoring will be incorporated into the program;
- Quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys;
- Fraud control provisions and monitoring; and,
- Monitoring for the effects of any undue burden on categorically needy optional families due to the premiums imposed through this demonstration.

h) **Grievances and Appeals.** If the grievances and appeals policies differ from non-demonstration Medicaid, then provide a description of the grievance and appeal policies that will be in place in the demonstration and how the process will be monitored.

i) **Evaluation Design.** The State will provide a more detailed description of the State's evaluation design included in its approved proposal, including:

1. A discussion of the demonstration hypotheses that will be tested;
2. Outcome measures that will be included to evaluate the impact of the demonstration;
3. What data will be utilized;
4. The methods of data collection;
5. How the effects of the demonstration will be isolated from those other initiatives occurring in the State;
6. Any other information pertinent to the State's evaluative or formative research via the demonstration operations;
7. The number of individuals whose eligibility is terminated for nonpayment of required premiums; and,
8. How the premium structure will be monitored against undue burden on participants/eligibles.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits that are established in accordance with Attachment B (Monitoring Budget Neutrality).

2. a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line lO.b, in lieu of Lines 9 or lOc. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or lO.c, as instructed in the State Medicaid manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.b.

   b. For each demonstration year, a separate Form CMS-64.9 WAIVER and/or 64.9P WAIVER will be submitted reporting expenditures for individuals enrolled in the demonstration. The sum of the quarterly expenditures for all demonstration years will represent the expenditures subject to the budget neutrality cap (as defined in 2.c.). The procedures for the reporting to these expenditures will be described in the Operational Protocol.

   c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of individuals who are enrolled in the demonstration. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and will be reported on Form CMS 64.9 WAIVER and/or 64.9P WAIVER.

   d. Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the demonstration will be reported to CMS on the CMS-64 Summary Sheet on Line 9.D., in order to assure Medicaid is properly credited with premium collections.

e. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs will be identified on the Forms CMS-64.10 WAIVER and/or 64.1 OP WAIVER.

f. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

g. The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol (see Section VII).

3. a. For the purpose of calculating the budget neutrality expenditure cap referenced in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined below. This information should be provided to CMS in conjunction with the quarterly progress report referred to in Special Term and Condition III-2. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section VII).

b. The term, "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

c. The term "demonstration eligibles" refers to categorically needy optional children: 1) under age 1 whose family income exceeds 185 percent FPL; 2) Age 1 through 5 whose family income exceeds 133 percent FPL; and, 3) Age 6 through 18 whose family income exceeds 100 percent FPL.

4. The standard Medicaid funding process will be used during the demonstration. Washington must estimate total matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, me estimate of matchable demonstration expenditures (total computable/federal share) subject to the budget neutrality cap must be separately reported by quarter for each federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in Attachment B. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

5. CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits referenced in Attachment B:

   a. Administrative costs, including those associated with the administration of the demonstration.
   b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.
   c. Net medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration.

6. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

ATTACHMENT B
MONITORING BUDGET NETURALITY

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, Washington will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number ofeligibles. By providing FFP for all eligibles, CMS will not place Washington at risk for changing economic conditions. However, by placing Washington at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

Base Year Expenditures
The base year expenditure and per capita amounts, and demonstration years trended per capita amounts must be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments; if necessary adjustments must be made. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act.

The base year is federal fiscal year 2002 and constitutes historical expenditure and utilization data provided by Washington for demonstration eligibles. Base year expenditure and enrollment data (calculated in member months) were used to calculate base year per capita costs for current eligibles under this demonstration. The base year cost is $102.16.

Base year expenditures and trended per capita amounts were not included for Medicaid State Plan amendments submitted after the established base year. All State Plan amendments submitted before or during the base year must be reflected in the base year data finalized with CMS.

Projecting Service Expenditures

Each demonstration year (DY) budget estimate ofMedicaid service expenditures will be calculated as the product of the monthly per person cost times the actual number of eligible/member months trended annually as reported to CMS by the State under the guidelines set forth in Attachment A number 3.a. If the Demonstration Years do not align with the established base year. Demonstration Year budget limits must be calculated by pro-rating the agreed-upon annual trend rate for the appropriate number of months.

Using the trend rates to produce Demonstration Year PMPM cost estimates

Since the beginning and the end of the demonstration do not coincide with the base year, the following methodology was used to produce DY PMPM cost limits. Using a monthly equivalent growth rate, the appropriate number of monthly trend factors was used to convert base year PMPM costs to PMPM costs for the first DY. The formula for the monthly equivalent rate of 7.2 percent is $(1.072)^{1/n}$ = 1.005811 or .5811 percent. To convert the FFY 2002 base year cost to DY1 per capita cost (a period of 29 months) the following formula was applied: 102.16 x $[(1.05811)^{29}]$ = $120.85. The first DY 1 begins February 1, 2004 through January 31,2005. After the first DY, the annual trend factor of 7.2 percent will be used to trend forward from one year to the next.

The per capita budget ceiling for each demonstration year for trend rate for Demonstration Population Eligibles (Categorically Needy optional Children) is listed below.

Demonstration Year	Per Member Per Month (PMPM)	Annual Trend Rate
2004	$120.85	7.2%
2005	$129.55	7.2%
2006	$138.88	7.2%
2007	$148.87	7.2%
2008	$159.59	7.2%

How the limit will be applied

The limit calculated above from the trended service expenditures will apply to actual expenditures for demonstration services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for beneficiaries and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Yearl	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

EXHIBIT 2

Budget Neutrality Computation

Without Waiver							
	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY 2004-08
Eligibles (a)	162,958	176,006	186,767	198,068	209,369	220,670	
Per Capita (b)	$ 117.40	$ 125.86	$ 134.92	$ 144.63	$ 155.05	$ 166.21	
Expenditures - Total	$ 229,584,315	$ 265,821,353	$ 302,382,812	$ 343,768,766	$ 389,546,434	$ 440,133,989	$ 1,531,103,680
Federal Share	$ 114,792,158	$ 132,910,677	$ 151,191,406	$ 171,884,383	$ 194,773,217	$ 220,066,995	$ 765,551,841

With Waiver							
	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY 2004-08
Eligibles (c)	162,958	171,075	181,534	192,518	203,503	214,487	
Per Capita (b)	$ 117.40	$ 125.86	$ 134.92	$ 144.63	$ 155.05	$ 166.21	
Expenditures - Total	$ 229,584,315	$ 258,373,171	$ 293,910,181	$ 334,136,534	$ 378,631,522	$ 427,801,645	$ 1,494,635,723
Premium Revenue (d)	$ (1,900,821)	$ (7,507,991)	$ (7,528,960)	$ (8,472,690)	$ (8,956,119)	$ (9,439,531)	$ (34,366,580)
Expenditures - Net	$ 227,683,494	$ 250,865,181	$ 286,381,221	$ 325,663,845	$ 369,675,404	$ 418,362,115	$ 1,460,269,144
Federal Share	$ 113,841,747	$ 125,432,590	$ 143,190,611	$ 162,831,922	$ 184,837,702	$ 209,181,057	$ 730,134,572

Difference							
	FFY 2004	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY 2004-08
Eligibles	0	(4,932)	(5,233)	(5,550)	(5,866)	(6,183)	
Caseload Reduction	0	(7,448,182)	(8,472,631)	(9,632,232)	(10,914,912)	(12,332,344)	$ (36,467,957)
Premium Revenue	(1,900,821)	(7,507,991)	(7,528,960)	(8,472,690)	(8,956,119)	(9,439,531)	$ (34,366,580)
Expenditures - Total	$ (1,900,821)	$ (14,956,173)	$ (16,001,591)	$ (18,104,922)	$ (19,871,031}	$ (21,771,875)	$ (70,834,537)
Federal Share	$ (950,411)	$ (7,478,087)	$ (8,000,795)	$ (9,052,461)	$ (9,935,515)	$ (10,885,938)	$ (35,417,269)

(a) From Premium Computations, columns D and G
(b) From Table 1C - Per Capita Trend
(c) From Premium Computations, columns E and H
(d) From Premium Computations, columns N and Q

Department of Social and Health Services
Medical Assistance Administration
Budget Neutrality Estimates
March 25, 2004

FFY02 Expenditures by Service Optional Non-Grant Eligible Children	
In-Patient	$5,153,082.75
Out-Patient	$5,001,532.96
Physicians	$6,762,942.36
Dental	$19,721,670.80
Drugs - Net of Rebates	$3,733,698.96
Lab/Xray	$149,396.87
Home Health	$6,867.24
Managed Care Premiums	$102,768,480.66
Capitated Payments for MH Care	$22,169,919.09
Vision Care	$1,262,612.43
Chiropractor	$7,025.75
Indian Health	$2,383,780.37
Transportation	$982,380.84
DME	$510,558.43
Family Planning	$347,781.36
Other Services	$9,812,853.83
Total FFY02 Expenditures	$180,774,584.70

JFFY02 Optional Eligible Children	$147.455.08
IFFY Optional Children's Per Capita	$102.16

Expenditures by Calendar Year
Medicaid CN Non-Grant Children

	Optional
FFY98	$65,994,723
FFY99	$89,673,819
FFYOO	$129,650,148
FFY01	$156.958,605
FFY02	$180,774,585

Rates of Growth in Expenditures
Medicaid CN Non-Grant Children

	Optional
FFY98	
FFY99	35.9%
FFYOO	44.6%
FFY01	21.1%
FFY02	15.2%

Includes expenditures for medical assistance, mental health costs (IP and RSNs), and drug/alcohol treatment. Excludes costs for children in Adoption Support.

Average Eligibles
Medicaid CN Non-Grant Children

	Optional
FFY98	$69,315
FFY99	$85,935
FFY00	$108,822
FFY01	$128,734
FFY02	$147,455

Rates of Growth in Average Eligibles
Medicaid CN Non-Grant Children

	Optional
FFY98	
FFY99	24.0%
FFY00	26.6%
FFY01	18.3%
FFY02	14.5%

Per Capita Costs
Medicaid CN Non-Grant Children

	Optional
FFY98	$79.34
FFY99	$86.96
FFYOO	$99.28
FFY01	$101.60
TFY02''	$102.16

Rates of Growth in Per Capita Costs
Medicaid CN Non-Grant Children

	Optional
FFY98	
FFY99	9.6%
FFY00	-14.2%
FFY01	2.3%
FFY02	0.6%
FFY98-01 Avg	9.4%
I-I-V98-U2Avg-	7.2%

Department of Social and Health Services
Medical Assistance Administration
Budget Neutrality Estimates
March 25, 2004

Premium And Caseload Reduction Computations

Implementation **July-04**

Month	CFC Feb04 Optional CN1055 Draft Forecast (1/23/04)	Children in Band A Income 100%-150%	0% Large percentage at implementation. Decrease In rate of growth thereafter	Reduction due to decrease in entries and increase in exits	Children in Band B Income 151%-200% discounted for Sneede-Kizer revs	6% & Large peroenBrae at implementation. Decrease In rate of growth thereafter	Reduction due to decrease in entries and increase in exits	Remaining clients after entries/exits - adjusted for family size	Remaining clients after entries/exits - adjusted for family size	Premium revenue from CN Optional Children between 100%-150% FPL			Premium revenue from CN Optional Children between 151%-200% FPL		
		51.762%	100%	Income 100%-150%	45.351%	——————^~	Income 151%-200%	100%-150%	151 %-200%						
			Income 100%-150%			Income 151%-200%		4.8747%	4.4635%	Caseload	Premiums	Revenue less failure to pay	Caseload	Premiums	Revenue less failure to pay
Jul-03	164.319	85,055	85,055	0	74,520	74.520	0	80,909	71,194	0	$0.00	$0	0	$0.00	$0
Aun-03	164,564	85,182	85,182	0	74,631	74,631	0	81,030	71,300	0	$0.00	$0	0	$0.00	$0
Sep-03	164,680	85,242	85,242	0	74.684	74,684	0	81,087	71,350	0	$0.00	$0	0	$0.00	$0
Oct-03	164,094	84,938	84,938	0	74,418	74,418	0	80,798	71,096	0	$0.00	$0	0	$0.00	$0
Nov-03	164.315	85,053	85,053	0	74.518	74,518	0	80,907	71.192	0	$0.00	$0	0	$0.00	$0
Dec-03	165.011	85,413	85.413	0	74.834	74,834	0	81,249	71.494	0	$0.00	$0	0	$0.00	$0
Jan-04	165.695	85,767	85,767	0	75.144	75,144	0	81,586	71,790	0	$0.00	$0	0	$0.00	$0
Feb-04	166.368	86,115	86.115	0	75,450	75,450	0	81,917	72,082	0	$0.00	$0	0	$0.00	$0
Mar-04	167,031	86,459	88.459	0	75.750	75.750	0	82,244	72,369	0	$0.00	$0	0	$0.00	$0
Apr-04	167.684	86,797	86,797	0	76.046	76,046	0	82,566	72,652	0	$0.00	$0	0	$0.00	$0
May-04	168,328	87,130	87,130	0	76.339	76,339	0	82,883	72,932	0	$0.00	$0	0	$0.00	$0
Jun-04	168,964	87,459	87.459	0	76.627	76,627	0	83,196	73,207	0	$0.00	$0	0	$0.00	$0
Jul-04	170.545	88,277	88,277	0	77.344	77.344	0	83,974	73,892	83,974	$0.00	$0	73,892	$10.00	$628.082
Auo-04	172.065	89,064	89.064	0	78.033	78,033	0	84,722	74,550	84,722	$0.00	$0	74,550	$10.00	$633,675
Sep-04	173,528	89,821	89,821	0	78.697	78,697	0	85,442	75.184	85,442	$0.00	$0	75,184	$10.00	$639.064
Ocl-04	174.937	90,551	90,551	0	79,336	74.576	4,760	86,137	71,247	86,137	$0.00	$0	71,247	$10.00	$605,800
Nov-04	176.295	91,254	91.254	0	79.952	75.155	4.797	86,806	71.800	86,806	$0.00	$0	71,800	$10.00	$610.300
Dec-04	177.606	91,933	91.933	0	80,546	75,713	4,833	87,452	72.334	87,452	$0.00	$0	72,334	$10.00	$614.83»
Jan-05	178.873	92,588	92,588	0	81,121	76,254	4.867	88,075	72,850	88.075	$0.00	$0	72,850	$10.00	$619.225
Feb-OS	180,099	93,223	93,223	0	81.676	76,775	4,901	88,679	73,349	88,679	$0.00	$0	73,349	$10.00	(623,467
Mar-05	181.285	93.837	93,837	0	82.215	77,282	4.933	89,263	73,833	89,263	$0.00	$0	73,833	$10.00	$627.581
Aor-05	182,436	94,432	94.432	0	82.736	77,772	4,964	89,829	74,300	89,829	$0.00	$0	74,300	$10.00	$631,550
May-05	183.553	95,010	95.010	0	83.243	78,248	4,995	90.379	74,756	90,379	$0.00	$0	74,756	$10.00	$635.426
Jun-05	184,639	95.573	95.573	0	83.735	78.711	5.024	90.914	75,198	90,914	$0.00	$0	75,198	$10.00	$639.183
Jul-05	184.077	95,282	95.282	0	83.481	78.472	5.009	90,637	74.970	90,637	$0.00	$0	74,970	$10.00	$637.245
AUO-05	185,046	95,784	95.784	0	83.920	78,885	5.035	91,115	75,364	91,115	$0.00	$0	75,364	$10.00	$640.594
Sep-05	186,016	96,286	96,286	0	84.360	79,298	5,062	91,592	75,759	91,592	$0.00	$0	75,759	$10.00	$643.952
Od-05	186,986	96,788	96,788	0	84,800	79,712	5,088	92,070	76,154	92,070	$0.00	$0	76,154	$10.00	$647.30«
Nov-05	187.956	97,290	97.290	0	85.240	80,126	5.114	92,547	76,549	92,547	$0.00	$0	76,549	$10.00	$650.667
Dec-05	188,925	97,792	97,792	0	85.680	80,539	5,141	93,025	76,944	93,025	$0.00	$0	76,944	$10.00	$654.024
Jan-06	189,895	98,293	98,293	0	86.119	80,952	5,167	93,502	77,339	93,502	$0.00	$0	77,339	$10.00	$657,382
Feb-06	190,865	98,795	98.795	0	86,559	81,365	5,194	93,979	77,734	93,979	$0.00	$0	77,734	$10.00	$660,739
Mar-06	191.835	99,297	99,297	0	86.999	81.779	5.220	94.457	78.129	94,457	$0.00	$0	78,129	$10.00	$664,097
Apr-06	192,804	96,799	99,799	0	87.439	82.193	5.246	94,934	78,524	94,934	$0.00	$0	78,524	$10.00	$667.454
May-06	193.774	100,301	100,301	0	87.878	82.605	5,273	95,412	78,918	95.412	$0.00	$0	78,918	$10.00	$670.803
Jun-06	194.744	100,803	100,803	0	88,318	83.019	5,299	95,889	79,313	95,889	$0.00	$0	79,313	$10.00	$674.161
Jul-06	195.714	101,305	101.305	0	88.758	83.433	5.325	96.367	79.708	96.367	$0.00	$0	79,708	$10.00	$677.518
Auo-06	196.683	101,807	101.807	0	89,198	83,846	5,352	96,844	80,104	96,844	$0.00	$0	80,104	$10.00	$680,864
Sep-06	197,653	102,309	102,309	0	89,638	84,260	5,378	97,322	80,499	97,322	$0.00	$0	80,499	$10.00	$684,242
Oct-06	198,623	102,811	102,811	0	90,077	84,672	5.405	97,799	80,893	97,799	$0.00	$0	80,893	$10.00	$687,591
Nov-06	189.593	103,313	103.313	0	90.517	85,086	5,431	98,277	81,288	98,277	$0.00	$0	81,288	$10.00	$690,948
Dec-06	200.562	103,815	103,815	0	90,957	85,500	5.457	98,754	81,683	98,754	$0.00	$0	81,683	$10.00	$694.306
Jan-07	201,532	104,317	104,317	0	91.397	85,913	5.484	99,232	82,078	99,232	$0.00	$0	82,078	$10.00	$697.663
Feb-07	202,502	104,819	104,819	0	91,837	86,327	5,510	99,709	82,474	99,709	$0.00	$0	82,474	$10.00	$701,029
Mar-07	203.472	105,321	105,321	0	92.276	86,739	5,537	100,187	82,868	100,187	$0.00	$0	82,868	$10.00	$704,378
Aor-07	204,441	105,823	105.823	0	92.716	87,153	5.563	100,664	83.263	100,664	$0.00	$0	83,263	S10.00	$707.736
May-07	205,411	106,325	106,325	0	93,156	87,567	5,589	101,142	83,658	101,142	$0.00	$0	83,658	$10.00	$711.093
Jun-07	206,381	106,827	106.827	0	93.596	87,980	5.616	101,620	84,053	101,620	$0.00	$0	84,053	$10.00	$714,451
Jul-07	207.351	107.329	107.329	0	94.036	88.394	5.642	102.097	84.448	102,097	$0.00	$0	84,448	$10.00	$717,808
Aug-07	208,320	107,831	107.831	0	94,475	88,807	5.668	102,575	84,843	102,575	$0.00	$0	84,843	$10.00	$721,166

Premium And Caseload Reduction Computations

B	C	D	E	F	G	H	I	J	K						
			0%			6%				Premium revenue from CN Optional Children between 100%-150% FPL			Premium revenue from CN Optional Children between 151%-200% FPL		
Month	CFC Feb04 Optional CN1055 Draft Forecast (1/23/04)	Children in Band A Income 100%-150%	Large percentage at implementation. Decrease in rate of growth thereafter	Reduction due to decrease in entries and increase in exits	Children in Band B Income 151%-200% discounted for Sneede-Kizer revs	Large percentage at implementation. Decrease in rate of growth thereafter	Reduction due to decrease in entries and increase in exits	Remaining clients after entries/exits - adjusted for family size	Remaining clients after entries/exits - adjusted for family size						
		51.762%	100%	Income 100%-150%	45.351%	94%	Income 151%-200%	100%-150%	151%-200%						
Sep-07	209,290	108,333	108,333	0	94,915	89,220	5,695	103,052	85,238	103,052	$0.00	**$0**	85,238	$10.00	**$724,523**
Oct-07	210,260	108,835	108,835	0	95,355	89,634	5,721	103,530	85,633	103,530	$0.00	**$0**	85,633	$10.00	**$727,881**
Nov-07	211,230	109,337	109,337	0	95,795	90,047	5,748	104,007	86,028	104,007	$0.00	**$0**	86,028	$10.00	**$731,238**
Dec-07	212,199	109,839	109,839	0	96,235	90,461	5,774	104,485	86,423	104,485	$0.00	**$0**	86,423	$10.00	**$734,596**
Jan-08	213,169	110,341	110,341	0	96,674	90,874	5,800	104,962	86,817	104,962	$0.00	**$0**	86,817	$10.00	**$737,945**
Feb-08	214,139	110,843	110,843	0	97,114	91,287	5,827	105,440	87,213	105,440	$0.00	**$0**	87,213	$10.00	**$741,311**
Mar-08	215,109	111,344	111,344	0	97,554	91,701	5,853	105,916	87,608	105,916	$0.00	**$0**	87,608	$10.00	**$744,668**
Apr-08	216,078	111,846	111,846	0	97,994	92,114	5,880	106,394	88,003	106,394	$0.00	**$0**	88,003	$10.00	**$748,026**
May-08	217,048	112,348	112,348	0	98,433	92,527	5,906	106,871	88,397	106,871	$0.00	**$0**	88,397	$10.00	**$751,375**
Jun-08	218,018	112,850	112,850	0	98,873	92,941	5,932	107,349	88,792	107,349	$0.00	**$0**	88,792	$10.00	**$754,732**
Jul-08	218,988	113,352	113,352	0	99,313	93,354	5,959	107,826	89,187	107,826	$0.00	**$0**	89,187	$10.00	**$758,090**
Aug-08	219,957	113,854	113,854	0	99,753	93,768	5,985	108,304	89,582	108,304	$0.00	**$0**	89,582	$10.00	**$761,447**
Sep-08	220,927	114,356	114,356	0	100,193	94,181	6,012	108,781	89,978	108,781	$0.00	**$0**	89,978	$10.00	**$764,813**
Oct-08	221,897	114,858	114,858	0	100,632	94,594	6,038	109,259	90,372	109,259	$0.00	**$0**	90,372	$10.00	**$768,162**
Nov-08	222,867	115,360	115,360	0	101,072	95,008	6,064	109,737	90,767	109,737	$0.00	**$0**	90,767	$10.00	**$771,520**
Dec-08	223,836	115,862	115,862	0	101,512	95,421	6,091	110,214	91,162	110,214	$0.00	**$0**	91,162	$10.00	**$774,877**
Jan-09	224,806	116,364	116,364	0	101,952	95,835	6,117	110,692	91,557	110,692	$0.00	**$0**	91,557	$10.00	**$778,235**
Feb-09	225,776	116,866	116,866	0	102,392	96,248	6,144	111,169	91,952	111,169	$0.00	**$0**	91,952	$10.00	**$781,592**
Mar-09	226,746	117,368	117,368	0	102,831	96,661	6,170	111,647	92,347	111,647	$0.00	**$0**	92,347	$10.00	**$784,950**
Apr-09	227,715	117,870	117,870	0	103,271	97,075	6,196	112,124	92,742	112,124	$0.00	**$0**	92,742	$10.00	**$788,307**
May-09	228,685	118,372	118,372	0	103,711	97,488	6,223	112,602	93,137	112,602	$0.00	**$0**	93,137	$10.00	**$791,665**
Jun-09	229,655	118,874	118,874	0	104,151	97,902	6,249	113,079	93,532	113,079	$0.00	**$0**	93,532	$10.00	**$795,022**
Jul-09	230,625	119,376	119,376	0	104,591	98,316	6,275	113,557	93,927	113,557	$0.00	**$0**	93,927	$10.00	**$798,380**
Aug-09	231,594	119,878	119,878	0	105,030	98,728	6,302	114,034	94,321	114,034	$0.00	**$0**	94,321	$10.00	**$801,729**
Sep-09	232,564	120,380	120,380	0	105,470	99,142	6,328	114,512	94,717	114,512	$0.00	**$0**	94,717	$10.00	**$805,095**
FFY04	167,802	86,858	86,858	0	76,100	76,100	0	82,624	72,703	21,178		**$0**	18,636		**$1,900,821**
FFY05	181,238	93,813	93,813	0	82,193	77,262	4,932	89,240	73,813	89,240		**$0**	73,813		**$7,507,991**
FFY06	192,319	99,548	99,548	0	87,219	81,986	5,233	94,696	78,326	94,696		**$0**	78,326		**$7,528,960**
FFY07	203,956	105,572	105,572	0	92,496	86,946	5,550	100,426	83,066	100,426		**$0**	83,066		**$8,472,690**
FFY08	215,593	111,595	111,595	0	97,774	91,907	5,866	106,155	87,805	106,155		**$0**	87,805		**$8,956,119**
FFY09	227,230	117,619	117,619	0	103,051	96,868	6,183	111,886	92,544	111,886		**$0**	92,544		**$9,439,531**

	Sum of months
FFY04	59,179
FFY05	62,798
FFY06	66,697
FFY07	70,397
FFY08	74,197
FFY09	86,943